

Health History for Children, Youth, and Adults Attending Nature Camps, Inc.

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form is to be filled in by parents/guardians of minors or by adults themselves.

Name _____ Birth Date ____/____/____ Age at Camp _____ Male Female
Last First Middle

Home Address _____

Parent/Guardian _____ Home Phone _____ Cell _____

Home Address (if different from Child's) _____

Business Address _____ Business Phone _____

Parent/Guardian _____ Home Phone _____ Cell _____

Home Address (if different from Child's) _____

Business Address _____ Business Phone _____

If neither parent (above) is available, in Emergency, notify:

Name _____ Home Phone _____ Cell _____

Address _____ Relationship to Participant _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate Carrier or Plan Name _____ Insurance ID # _____ Group # _____

Address of Carrier _____

Name of Insured _____ Relationship to Participant _____

Important! This box MUST be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person here-in described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, injections, anesthesia, or surgery for the person named above. This completed form may be photocopied for trips out of camp.

Signatures of Parents/Guardians or Adult Staffer _____ Date ____/____/____

_____ Date ____/____/____

Printed Names of Parents/Guardians _____

I, the participant named above, also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of Minor Camper or Adult Staffer _____ Date ____/____/____



* If for religious reasons you cannot sign this form, contact the camp for a legal waiver which must be signed for attendance.

Health History

The following information must be filled in by the parent/guardian or adult staffer. The intent of this information is to provide Nature Camps, Inc. health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to Nature Camps, Inc. health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES: List all known.	Describe reaction and management of the reaction
Medication Allergies (list)	
Food Allergies (list)	
Other Allergies (list) Include insect stings, hay fever, asthma, animal dander, etc.	

Medications Being Taken

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep medications in original packaging/bottle that identifies the participant's name, prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.**

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med # 1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med # 2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med # 3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

Med # 1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med # 2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Restrictions

The following restrictions apply to this individual.

Dietary Does not eat eggs Does not eat dairy products Does not eat meat
 Other _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Health Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. knees, ankles, etc.)? .	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? .	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question:

Which of the following has the participant had?

Measles
 Chicken pox
 German measles
 Mumps
 Hepatitis A
 Hepatitis B
 Hepatitis C

Please give all dates of immunizations for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_/_	_/_	_/_	_/_	_/_	_/_
TD (tetanus/diphtheria)		_/_	_/_	_/_	_/_	_/_	_/_
Tetanus		_/_	_/_	_/_	_/_	_/_	_/_
Polio		_/_	_/_	_/_	_/_	_/_	_/_
MMR		_/_	_/_				
or Measles		_/_	_/_				
or Mumps		_/_	_/_				
or Rubella		_/_	_/_				
Haemophilus influenza B		_/_	_/_	_/_	_/_		
Hepatitis B		_/_	_/_	_/_			
Varicella (chicken pox)		_/_	_/_				

Use this space to provide any additional information about the participant's behavior, and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist _____ Phone _____

Address _____

Name of family orthodontist _____ Phone _____

Address _____

